IN THE SUPERIOR COURT OF THE STATE OF DELAWARE
IN AND FOR NEW CASTLE COUNTY

BARBARA S. IZARD and CARROLL E. IZARD, Plaintiffs,	)	
v.	)	
ECKERD CORPORATION PHARMACIST MCK, MICHAEL E. KING, PHARMACIST, MICHAEL KING, PHARMACIST, Defendant/ Third Party Plaintiffs,	)	C.A. No.: 07C-03-319 FSS **E-FILED**
v.	)	
PharmPro, Inc. Third Party Defendant.	)	

Submitted: February 10, 2011
Decided: May 31, 2011

MEMORANDUM OPINION AND ORDER

Upon Defendants' Motions for Dismissal and Summary Judgment –
GRANTED

SILVERMAN, J.

This very old personal injury case concerns an alleged Coumadin® overdose caused by a negligently filled prescription. Plaintiff, who passed away from other causes while this case has dragged-on, claims that in March 2005, Defendants mis-filled her prescription, causing her hospitalization. Now, Defendants – the pharmacy and pharmacist – seek dismissal or summary judgment on two grounds. First, Defendants detail Plaintiff's chronic indifference to the court's rules and scheduling orders. Second, Defendants highlight the meagerness of the evidence Plaintiff has cobbled together over the past six years.

Specifically, Defendants challenge Plaintiff's naming experts and producing their reports long after the scheduling order's deadline. In the worst example, fifteen months after the deadline, three months after the first court-ordered trial date, and after the court threatened dismissal "without further notice or opportunity to be heard," Plaintiff provided bare-bones affidavits from a pharmacy practices and a medical expert. Plaintiff's false assurances, described below, also backed the court into continuing the trial.

Not only were the expert reports too late, according to Defendants they are too little. Defendants' substantive challenge to the experts features the fact that the pharmacy expert's investigation was cursory. It did not include the experts' speaking directly with Plaintiff in the years following the alleged overdose and before

her death. Nor did the pharmacy expert see the prescription or the pills in dispute. Relying entirely on the deceased Plaintiff's hearsay-on-hearsay, he concludes that the prescription was mis-filled and, therefore, Defendants were negligent. As also discussed below, this is despite the undisputed fact that when she was hospitalized and bleeding excessively, Plaintiff never mentioned her allegedly open concern that she had received and taken the wrong-strength pills.

I.

As implied at the outset, procedurally this case is an embarrassment. The tort allegedly happened on March 28, 2005. Almost at the last-moment before the statute of limitations had run, Plaintiff filed suit – against the wrong pharmacy. Three months later, Plaintiff agreed to drop that pharmacy-defendant, leaving Plaintiff with one defendant. Seven months after that, Plaintiff amended her complaint to name another pharmacy-defendant. Thus, ten months after filing suit and almost three years after the alleged tort, Plaintiff had managed to name the defendants to her complaint, but she still had not completed service.

Four months after the court allowed Plaintiff to file her amended complaint, the court issued its informal "no action" letter, warning Plaintiff the case was subject to dismissal for lack of timely service under Superior Court Civil Rule

4(j).[1] The first threat of dismissal worked, but only briefly. Anyway, the complaint was served. Then, Plaintiff went back to doing nothing. So, in October 2008, the court issued its "no answer" letter, calling Plaintiff's attention to her failure to insist that Defendants answer her complaint. The second letter/order did not even get a rise from Plaintiff.

Meanwhile, the originally-assigned judge retired, and immediately after the case's reassignment in February 2009, the court issued its first notice of dismissal under Superior Court Civil Rule 41(e). The notice prompted another short-lived flurry of activity, ending with the last response to the amended complaint being filed February 24, 2009. Thus, it took almost four years after the alleged tort, two years after the complaint, and a warning followed by two threats of dismissal before the complaint was answered.

With the court's two-year struggle to get the complaint filed and answered finally over, on March 26, 2009, the court issued its first Trial Scheduling Order. The order called for Plaintiff to file her expert reports immediately. Trial was set to start more than a year later, on April 26, 2010.

During that time, Plaintiff passed away. On July 10, 2009, Plaintiff filed

[1]Super. Ct. Civ. R. 4(e) in pertinent part states: The Court may order an action dismissed, *sua sponte*, upon notice of the Court, for failure of a party diligently to prosecute the action . . . .

a suggestion of death,[2] showing that Mrs. Izard had died three months earlier, on April 13, 2009. On November 5, 2009, the court again pressed Plaintiff for details. Plaintiff responded two months later, on January 8, 2010, assuring the court that Plaintiff's death "has irrevocably transformed the case into a wrongful death claim . . . ." It did no such thing.

Plaintiff's unequivocal assurance that the case had been "irrevocably transformed" was untrue and misleading. After repeatedly rescheduling her motion to add the wrongful death claim, and further back-and-forth between the court and counsel, on July 12, 2010, Plaintiff dropped the wrongful death claim. By then, as further discussed next, the trial date passed.

On April 6, 2010, only weeks before the longstanding trial date, the court issued its second, Rule 41(e) notice of dismissal. In response, on April 16, 2010, Plaintiff's counsel told the court he had experienced serious and debilitating health problems that had interfered with his pursuing the case. On April 21, 2010, the court replied, expressing concern and asking for assurance that counsel could go forward. The court called for a response "by return mail." Two weeks later, on May 5, 2010, Plaintiff assured the court that he was able and Plaintiff's case was complete, including her expert reports.

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[2] Super. Ct. Civ. R. 41(e).

It was during the weeks that the court waited for the "return mail" from Plaintiff that the first trial date quietly passed. Basically, the feint toward the wrongful death claim and counsel's health obscured the fact that Plaintiff was doing almost nothing to prepare, and it worked a *de facto* trial continuance.

Trial continuances in civil cases are unusual. Rescheduling a civil trial not only increases the risk that a courtroom will be dark, it means another trial slot, which could be allocated to other litigants, must be given to the litigants who failed to take advantage of their first trial opportunity. And so, the court is reluctant to continue a civil trial. Had the court realized that the wrongful death claim was a vapor, it would have stood by its second notice of dismissal.

Last Fall, after the court-ordered trial date had passed, Defendants moved for dismissal and summary judgment. In Plaintiff's opposition, Plaintiff attempts to overcome a couple of shortcomings in her position by castigating Defendants for "blatant obstruction of evidence" and she cries foul over "unresolved discovery disputes." In the "blatant" instance, a request, made long after the time to raise discovery disputes was over, went unanswered. So, Plaintiff sent a follow-up letter, which also was not answered. Coming where and when they do, the court sees those untimely claims about discovery for what they are, and it is giving them the consideration they deserve.

II.

Substantively, Plaintiff can produce neither the prescription, the pill bottle in question, nor a hospital diagnosis of a Coumadin overdose. Plaintiff cannot produce a witness who saw the suspect pills, much less a witness to Plaintiff's taking one. The pharmacy records, which exist and are admissible, suggest the prescription was correct and properly filled. One doctor's report on Plaintiff's hospital admission at issue offers: "The likely etiology for her coagulopathy is her Iron supplements for which she started approximately 4 or 5 weeks ago." The report goes on, also unhelpfully to Plaintiff, "nor has there been any other changes in her medications recently in the past 4 to 5 weeks." In other words, the hospital did not believe it was treating a Coumadin overdose, and there is no reason to believe that Plaintiff even suggested the possibility to her hospital doctors. Plaintiff dismisses the hospital report as a "casual comment," which is an inadmissible expert opinion.

To refute the contrary evidence and make her case, Plaintiff, now deceased, has her typewritten, two-page "Narrative Report of Events Following A Pharmacy Error." Based on its contents, the "Narrative" was written in anticipation of litigation, at least nine months after the prescription was allegedly mis-filled.

The "Narrative" reads like a statement written by a plaintiff at her lawyer's suggestion. In it, Plaintiff claims she noticed the pills she got from the

pharmacy were a different color than usual and she called the pharmacy. Someone, later identified as probably being Beth Pope, a cashier, told her, in effect, that the color change was due to a change in supplier. It claims that the head pharmacist, Joseph Stratton, admitted to Plaintiff the error by a former, unnamed pharmacy employee, probably Pope.

The "Narrative" says that after taking the medicine "for several days," Plaintiff began experiencing symptoms, including swollen knees. She went to an orthopedist who told her she had a "coumadin problem." Plaintiff reports she went to "the Coumadin Center," where "the technician" found Plaintiff's "INR was extremely high, 'off the scale'." Plaintiff went to the hospital where she was admitted and immediately given blood plasma." Plaintiff reports, "We were told that I was in a life threatening condition." She was discharged after seven days. The "Narrative" closes with a recitation of pain and suffering Plaintiffs experienced, ending with a summary of Plaintiff's "Out-of-pocket expenses and other damages; including Medical Expenses – $125,000.00."

Plaintiff's husband, in his deposition, confirms that Plaintiff was upset about the pills' color, but he had no personal recollection of the color. He also was unclear on how many, if any, of the "wrong" pills she took before she discarded the rest. He opined, "Obviously, she had took enough to have a huge overdose. . . . a

monstrous dose. . . ." Thus, he firmly believes that his wife suffered a massive overdose. But, to be clear, viewing the evidence in the light most favorable to Plaintiff, having thought she had been given the wrong pills, she threw them away, so no potential witness saw the pills, nor does anyone know how many Plaintiff took and over what time. The details are a matter of supposition.

And, Plaintiff's argument to the contrary notwithstanding, Plaintiff's elderly husband did not recall seeing or hearing any telephone conversation between Plaintiff and the pharmacy. At his deposition, near its end, he admitted "there's a lot of things jumbled around about [the phone call] because I've heard a lot about it today[, after listening to other's testify]." Then, the husband was asked, twice, whether he was in the room when Plaintiff made the call to the pharmacy. He testified, "I don't recall. Really, I don't recall." When asked if it were possible that he was not present in the room "when the actual call was being placed so that you could hear what your wife was saying," he answered: "It is."

The pharmacy manager, Joseph Stratton, was deposed. He recalled speaking with Plaintiff, by herself, on a Saturday, "several months" after the incident. At that point, Stratton "didn't have any knowledge that anything had occurred. . . ." The only thing that Stratton could offer of help to Plaintiff about their several months, after-the-fact conversation was he recalled Plaintiff saying that she thought she had

been given the wrong color pills. Stratton also said that Pope was cautioned, not in connection with Plaintiff's allegation, about "not overstepping her bounds" when answering customers' questions.

Plaintiff's pharmacy practices expert relies on the "Narrative" for his belief that Plaintiff "noticed the wrong color as soon as she got home with the first ten tablets . . . and thereon called the pharmacy and questioned it. . . . She was told by a clerk basically that it was the same, med but a different manufacturer and it's okay to take it." Like Plaintiff's husband, the pharmacy expert also uses circular reasoning to reach assumptions from his understanding of "the medical repercussions." But, as presented above, the fundamental problem with the pharmacy expert's opinion is its reliance on the "Narrative."

Plaintiff's medical expert, formerly her primary care physician, submitted an affidavit long after the deadline for expert discovery had passed. Plaintiff justifies ignoring that deadline on the basis that the doctor had been identified by Plaintiff from early on.

The affidavit is not entirely clear. In one conclusory sentence, the expert opines that Plaintiff probably suffered from a Coumadin overdose: "In light of the April 15, 2005 hospitalization, with the previously described presenting complaints, coupled with an INR of 29, it must necessarily follow that [Plaintiff] suffered from

an overdose of Wayfarin/Coumadin."

The expert says he relied on three Christina Care reports: one for 4/21/05, another for 4/23/05, and the third one for 4/18/05. Attached to Eckerds's and PharmPro's motion is the 4/15/05 "History and Physical" report by Dr. Declan Quigley, a doctor at the hospital. (It should be remembered that the admission date was April 15.) Whereas Plaintiff's expert recites Plaintiff's INR at admission as 29, Dr. Quigley's report, from the day of admission, states the INR was 25. More importantly, it is Dr. Quigley who opined that Plaintiff's admission was related to her Iron therapy.

It does not appear that Plaintiff's expert reviewed the report by Dr. Quigley on the physical exam performed and the history taken on admission. Thus, the opinion is suspect as having been based on incomplete or selective investigation. Moreover, it seems that the expert's syllogism is: Plaintiff was on Coumadin; a Coumadin overdose will cause a high INR; Plaintiff had a high INR; therefore, Plaintiff had a Coumadin overdose. That fails because it ignores the possibility that a high INR may have other causes, such as Iron therapy. For present purposes, however, the court is focusing more on negligence, rather than causation.

Again, as to negligence, Plaintiff can prove through the "Narrative" that Plaintiff was prescribed an anti-coagulant. At one point, she was concerned her

pharmacy gave her the wrong strength pills, which if true would establish negligence. She took the pills for several days. Then, she was hospitalized with a serious coagulation problem. From that, despite the hospital's attributing her problem to another cause, Plaintiff's experts conclude that Plaintiff received the wrong pills, and she took enough of them to make her seriously ill before she threw the rest away. Even with the "Narrative," Plaintiff's negligence claim is sketchy.

Plaintiff, the Narrative's author, is unavailable to testify. So, Plaintiff seeks the Narrative's admission as substantive evidence. Plaintiff does not say clearly under what rule it comes in, or explain her comment that "the document stands on its own."

Defendants challenge the narrative as hearsay under D.R.E. 801. Plaintiff's out of court statement, which is offered for its truth, is hearsay. It is suggested that it might fit under D.R.E. 305(5)'s exception as a recorded recollection. That rule, however, only applies to a report or memorandum, such as the narrative, of "a witness." D.R.E.305(5) covers a witness who is missing a present memory, but who has a contemporaneously made report. It does not cover a missing witness. The narrative is inadmissible.

Plaintiff argues alternatively that even if the narrative cannot come in, Stratton's statement about what Plaintiff told him is an admission against interest. While that is true, Stratton's statement only repeats another of Plaintiff's hearsay

statements. It does not matter whether Plaintiff's hearsay is offered through her written narrative or through what she told Stratton. If Stratton testifies, he can only tell the jury what Plaintiff told him. The statement is being offered for its truth, not for the truth of whether it was made. If the jury hears Plaintiff's hearsay, Defendants cannot question her about it. Thus, Stratton's statement only admits he heard otherwise inadmissable hearsay.

III.

In summary, after years to prepare, Plaintiff was unprepared for trial, as ordered. Thus, Defendants were entitled to dismissal then. More importantly, even now Plaintiff cannot prove through admissible evidence that she received the wrong medicine from Defendants and she took it, despite her qualms, because an unqualified employee of Defendant said it was alright. In fact, without the pill bottle or, more importantly, the pills, or her admissible testimony, no one can even say if the alleged negligence involved Coumadin pills.

The court appreciates that Plaintiff had a bad experience in April 2005, and the court does not doubt the sincerity of hers and her husband's belief that Defendants are to blame. But, Defendants are entitled to have Plaintiff's claims presented in a timely, orderly, and reliable way. That has not happened. If this case goes to trial as is, Plaintiff will rely only on innuendo, supposition and sympathy, not admissible evidence and solid proof.

IV.

For the foregoing reasons, Defendants' motions to dismiss and for summary judgment are **GRANTED.**

IT IS SO ORDERED.

/s Fred S. Silverman
Judge

cc: Prothonotary (Civil)
Raymond J. Otlowski, Esquire
Gerald J. Hagar, Esquire
Colleen D. Shields, Esquire
Ryan S. Zavodnick, Esquire